RETURN DATE: APRIL 12, 2016	:	SUPERIOR COURT
DEBORAH CRAVEN,	:	J.D. OF NEW HAVEN
Plaintiff	:	AT NEW HAVEN
VS.	:	
YALE-NEW HAVEN MEDICAL CENTER, INC., AND YALE UNIVERSITY A/K/A YALE UNIVERSITY SCHOOL OF MEDICINE, ANTHONY KIM, M.D., AND RICARDO QUARRIE, M.D.	:	
Defendants.	:	MARCH 14, 2016

COMPLAINT

COUNT ONE – AS TO YALE-NEW HAVEN MEDICAL CENTER, INC., YALE UNIVERSITY A/K/A YALE UNIVERSITY SCHOOL OF MEDICINE, ANTHONY KIM, M.D. AND RICARDO QUARRIE, M.D. FOR NEGLIGENCE

1. At all times mentioned herein, the defendant, YALE-NEW HAVEN MEDICAL CENTER, INC. (YNHH), YALE UNIVERSITY A/K/A YALE UNIVERSITY SCHOOL OF MEDICINE and YALE UNIVERSITY SCHOOL OF MEDICINE (collectively YALE DEFENDANTS) were entities engaged in the practice of medicine and surgery through their agents, apparent agents, servants, employees, joint venturers and contractors, including the defendants, ANTHONY KIM, M.D. and RICARDO QUARRIE, M.D., within the State of Connecticut.

2. The plaintiff, DEBORAH CRAVEN, is a resident of the State of Connecticut.

3. At all times mentioned herein, the defendants, ANTHONY KIM, M.D. and RICARDO QUARRIE, M.D. were physicians licensed by the State of Connecticut and specializing in cardiothoracic surgery with an office in New Haven,

Connecticut, and were providing medical services to their patients, including the plaintiff, DEBORAH CRAVEN.

4. While under the care, treatment and supervision of the defendants herein, the plaintiff, DEBORAH CRAVEN, suffered serious, painful and permanent injuries as hereinafter set forth below.

5. The injuries were caused by the failure of the defendants and/or their servants, agents, apparent agents, contractors, joint venturers, principals and/or employees to provide the proper care and treatment expected of physicians and medical practitioners specializing in the field of cardiothoracic surgery.

6. On May 18, 2015 the plaintiff, DEBORAH CRAVEN, was admitted to YNHH for removal of a lesion located on her 8th rib by the defendant, ANTHONY KIM, and staff of YNHH.

7. Prior to proceeding with surgery, the defendants had radiologists mark the site of the lesion on the plaintiff's 8th rib in order for the surgical team to locate the proper rib and lesion for resection by placing metallic coils into the rib and injecting a marking dye into the skin and surrounding tissue.

8. Following the marking, the plaintiff underwent rib resection by the defendants.

9. Upon awakening, the plaintiff noted immediate pain in the region of the resection that persisted into the evening; whereupon, an x-ray was obtained by the defendants. The x-ray revealed that the metal markers were still in place and that a portion of the 7th rib had been removed rather than the 8th rib as intended.

10. After realizing the wrong rib was removed, the defendant, RICARDO QUARRIE, M.D., falsely informed the plaintiff that the defendants had not removed enough rib during the surgery and, for that reason, she would need to undergo

another surgery under general anesthesia with all the attendant risks and associated pain and disability.

11. Later that day, the plaintiff returned to the operating room and the correct rib was resected and the marking coils were removed.

12. In one or more of the following ways, defendants were negligent and failed to adhere to the standard of care in that (he, it, they):

a) failed to adequately and properly monitor and supervise the resident physician house staff;

b) failed to confirm intraoperatively with x-ray that the correct rib was being resected;

c) failed to remove the implanted marking coils prior to closing the surgical wound and leaving the operating room;

d) failed to obtain an x-ray prior to closing the surgical wound and leaving the operating room;

e) failed to recognize that the wrong rib had been operated on until after the plaintiff had recovered and returned to her hospital room; and,

f) misrepresented to the plaintiff the reason for her needing a repeat surgery.

13. As a result of the negligence of the defendants, the plaintiff, DEBORAH CRAVEN, was forced to suffer the following, including, but not limited to, serious, painful, potentially life threatening, and permanent injuries:

a) repeat surgery;

b) repeat intubation;

c) repeat general anesthesia; and,

d) severe physical and mental pain, suffering and disability.

14. As a consequence of sustaining the injuries set forth above, the plaintiff, DEBORAH CRAVEN, has been caused to suffer a limitation of her ability to carry on and enjoy all of life's activities.

15. As a further consequence of sustaining the injuries set forth above, the plaintiff, DEBORAH CRAVEN, has been caused to expend sums for medical expenses and will expend further sums into the future.

COUNT TWO – AS TO THE YALE DEFENDANTS AND RICARDO QUARRIE, M.D. FOR UNFAIR TRADE PRACTICES

1 Paragraphs 1-11 of Count One are herein incorporated as Paragraphs 1- 11 of Count Two.

12. At all times relevant to this matter, the YALE DEFENDANTS and defendant QUARRIE through provision and distribution of medical services, were engaged in trade or commerce as defined by General Statutes § 42-110a(4).

13. The YALE DEFENDANTS, through their agent, QUARRIE, after knowing that the wrong body part had been removed from the plaintiff attempted to affirmatively conceal from the plaintiff the fact that they had removed the wrong body part by lying and misrepresenting the reason for the need for repeat surgery.

14. Despite the plaintiff's specific request, after learning that the YALE DEFENDANTS through the acts of QUARRIE, attempted to cover up the removal of the wrong body part, that QUARRIE not participate in any further treatment of the plaintiff, including the second surgery necessitated by the prior removal of the wrong body part, the defendants unscrupulously acted for their own pecuniary benefit by permitting QUARRIE to assist with and/or perform the second surgery and receiving compensation for those services and/or billing the plaintiff and her insurers for the QUARRIE services.

15. These actions, policies and practices of the YALE DEFENDANTS and defendant QUARRIE, as set forth above, constitute unfair and deceptive

business practices in violation of the Connecticut Unfair Trade Practices Act, General Statutes § 42-110(b).

16. As a result of the above-mentioned unfair and deceptive business practices, the plaintiff, DEBORAH CRAVEN, suffered an ascertainable loss including injury, repeated unnecessary surgery, emotional distress and economic loss.

WHEREFORE, THE PLAINTIFF HEREBY CLAIMS MONETARY DAMAGES INCLUDING PUNITIVE DAMAGES AND ATTORNEY'S FEES IN EXCESS OF FIFTEEN THOUSAND & 00/100 DOLLARS ($15,000.00), AND THIS MATTER IS WITHIN THE JURISDICTION OF THIS COURT.

THE PLAINTIFF,

By: _____

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PLEASE ENTER THE APPEARANCE OF FAXON LAW GROUP, LLC FOR THE PLAINTIFF

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CERTIFICATE

Pursuant to General Statutes §§ 52-190(a) and 52-184(c), I hereby certify that I have made reasonable inquiry, as permitted by the circumstances, to determine whether there are grounds for a good faith belief that there has been negligence in the care and treatment of the plaintiff, DEBORAH CRAVEN. This inquiry has given rise to a good faith belief on my part that grounds exist for an action against each named defendant. A copy of a written and signed opinion (name expunged) of a health care provider similar to the defendants is attached herewith as Exhibit A. The written and signed opinion indicates that there is evidence of medical negligence, and it includes a detailed basis of that opinion.

ATTORNEY FOR THE PLAINTIFF,

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Exhibit A

I have been asked by the Faxon Law Group to review the medical care and treatment of Deborah Craven by the thoracic surgical service at Yale-New Haven Hospital. I am a board certified cardiothoracic surgeon and have been in active practice for the past 20 years and am familiar with the standard of care in cardiothoracic surgery. I reviewed Ms. Craven's medical records from Yale-New Haven Hospital and have concluded that there is evidence that Ms. Craven' care from Dr. Anthony Kim and staff deviated from appropriate standards.

Ms. Craven was referred to Dr. Kim for the removal of a lesion on the posterior aspect of her left 8th rib that had been discovered due to a work up for thoracic back pain. On May 18, 2015, Ms. Craven was admitted to YNHH for removal of this lesion and a portion of her 8th rib. Prior to the surgery, the correct rib was localized by radiology and "marked" by placing metal coils into the rib and injecting a blue dye into the skin and surrounding tissue in order for the surgeons to operate on the appropriate rib containing the suspect lesion. The surgery was performed by Dr. Kim and/or his residents/staff wherein a portion of rib was removed and without removing the metal coil marker or noting its presence, the patient was closed and admitted for recovery. Later that day, the patient complained of severe pain in the area of the surgery and an x-ray was obtained which revealed that the marking coil was still present and that a portion of the 7th rib had been removed and not the 8th as planned. The following day, 5/19/15, Ms. Craven was informed of this error by Dr. Kim and later that day, taken back to the operating room for removal of the correct rib, its lesion, and marking coils. Confirmatory imaging studies were obtained prior to leaving the operating room at that surgery. Moreover, the standard of care requires that healthcare providers inform their patients of the reasons for medical procedures offered them.

Dr. Kim and his resident/fellow, Dr. Ricardo Quarrie, failed to meet the standard of care expected of a thoracic surgeon in operating on the wrong rib because he failed to confirm the correct rib intraoperatively with an x-ray or fluoroscopy. Furthermore, it was also below the standard of care to not obtain an x-ray prior to leaving the operating room especially since the metal markers were not recovered during the surgery and therefore, were simply left behind in Ms. Craven's 8th rib. Had Dr. Kim and Dr. Quarrie recognized that the coils were still in place, they would have realized that a portion of the wrong rib had been removed and proceeded to remove the appropriate rib and lesion without the need for subjecting Ms. Craven to a second surgery and its attendant risks as was done here. Lastly, all physicians owe a duty to their patients to inform them truthfully about issues concerning their health including the reasons behind performing a repeat surgery. In this case, according to the patient, Dr. Kim met this

standard but his resident/fellow, Dr. Quarrie, did not by reportedly informing Ms. Craven that the reason for the second surgery was that "they did not remove enough rib" during the first surgery as opposed to the truth which was that the wrong rib was operated on.

The failure to verify the localization of the appropriate rib and lesion for removal followed by closure of the patient without final verification before awakening the patient and leaving the operating room knowing or not realizing that localization markers were still within the patient are clearly acts below the standard of care that should be exercised by a thoracic surgeon and is evidence of medical negligence. Furthermore, misrepresenting to the patient the true reason for having to undergo a repeat surgery is below the standard of care expected of all physicians and is also evidence of medical negligence. I reserve the right to edit or amend this opinion should further facts regarding this case become known to me.

Sincerely,